DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Center for Mental Health Services

Request for Applications (RFA) No. TI 03-003

State Incentive Grants (COSIG) for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders

Short Title: COSIG

Part I- Programmatic Guidance

June 13, 2003

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[Note to Applicants: To prepare a complete application, "Part II – General Policies and Procedures Applicable to all SAMHSA Applications for Discretionary Grants and Cooperative Agreements," must be used in conjunction with this document, "Part I - Programmatic Guidance."]

Agency

Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration

Purpose of this Announcement

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), and Center for Mental Health Services (CMHS), are accepting applications for Fiscal Year 2003 grants to develop and enhance the infrastructure of States and their treatment service systems to increase the capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with co-occurring substance abuse and mental health disorders, and their families.

It is expected that approximately $6.5 million will be available for 6 to 10 awards in FY 2003. The average annual award will range from $500,000 to $1.1 million in total costs (direct and indirect). Grantees in years 1-3 will receive up to $1.1 million per year. Grantees with service pilots will receive up to half of the third year award in the 4th year to phase down the services pilot and up to $100,000 for evaluation in year 5. Grantees without service pilots will receive up to $100,000 for evaluation in both years 4 and 5. Applications with proposed budgets that exceed these amounts in any year will be returned without review.

Cost sharing is not required in this program. Actual funding levels will depend on the availability of funds.

Awards may be requested for up to 5 years. Annual continuation awards will depend on the availability of funds and progress achieved.

This program addresses key elements of SAMHSA/CSAT's "Changing the Conversation: Improving Substance Abuse Treatment: The National Treatment Plan (NTP) Initiative." This program specifically addresses two NTP key elements:

- "Building Partnerships" by requiring close partnerships among the mental health, substance abuse, and other systems; and
- "No Wrong Door" to treatment by providing access to treatment for persons with mental and substance abuse disorders.

For additional information about the NTP and how to obtain a copy, see Appendix B.

Who Can Apply?

Only the immediate Office of the Governor of States may apply. State-level agencies are not considered to be part of the immediate Office of the Governor. This means, for example, that the State Mental Health or Substance Abuse Authorities or other State-level agencies within the Office of the Governor cannot apply independently. SAMHSA has limited the eligibility to Governors of States because the immediate Office of the Governor has the greatest potential to provide the multi-agency leadership needed to develop the State's infrastructure/treatment service systems to increase the State's capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based services to persons with co-occurring substance abuse and mental health disorders, and their families.

The Governor may designate a lead official to be Program Director for the grant. The application must reflect substantial involvement of the State Mental Health Authority (SMHA) and the State Substance Abuse Authority (SSA), and other relevant agencies, and must reflect substantial involvement and oversight by the immediate

Office of the Governor. The Governor must sign the application.

As defined in the Public Health Service (PHS) Act, the term "State" includes all 50 States, the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, American Samoa, and the Trust Territory of the Pacific Islands. Applications from State agencies other than the Office of the Governor, or from government entities that do not meet the definition of "State," are not eligible for funding and will not be reviewed.

This grant program is appropriate for all States regardless of their level of infrastructure development.

Application Kit

SAMHSA application kits include the following:

1. PHS 5161-1*(revised July 2000)* Includes the Face Page, Budget forms, Assurances, Certifications and Checklist.

2. PART I of the Program Announcement (PA) or Request for Applications (RFA) includes instructions for the specific grant or cooperative agreement application. This document is Part I.

3. PART II of the Program Announcement (PA) or Request for Applications (RFA) provides general guidance and policies for SAMHSA grant applications. The policies in Part II that apply to this program are listed in this document under "Special Considerations and Requirements."

You must use all of the above documents of the kit in completing your application.

How to Get an Application Kit

- Call: **the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686; or**

- Download **Part I, Part II and the PHS 5161-1** of the application kit from the SAMHSA web site at www.samhsa.gov. Click on "Grant Opportunities" and then "Current Grant Funding Opportunities."

- In addition to the application, **you may want to obtain a draft copy of SAMHSA's "Treatment Improvement Protocol (TIP), Substance Abuse Treatment for Persons with Co-occurring Disorders" and the "Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit," referred to in this grant announcement**. Please see the section, "How To Obtain SAMHSA's Treatment Improvement Protocol (TIP), Substance Abuse Treatment for Persons with Co-occurring Disorders" and "Co-Occurring Disorders: Integrated Dual Disorders Implementation Resource Kit." If copies are requested, they must be returned with the application, or the application will not be reviewed.

Where to Send the Application

Send the original and 2 copies of your grant application to:

Ray Lucero
Program Management Review Branch
OPS/SAMHSA
Parklawn Building, Room 17-89
5600 Fishers Lane
Rockville, MD 20857

All applications MUST be sent via a recognized commercial or governmental carrier. Hand carried applications will not be accepted. Faxed or e-mailed applications will not be accepted. You will be notified by letter that your application has been received.

Be sure to type "RFA TI 03-003" and "COSIG" in Item Number 10 on the face page of the application form.

Application Due Date

Your application must be received by June 13, 2003.

Applications received after this date must have a proof-of-mailing date from the carrier before June 6, 2003.

Private metered postmarks are not acceptable as proof of timely mailing. Late applications will be returned without review.

How to Get Help

For questions on program issues, contact:

Richard E. Lopez, J.D., Ph.D.
SAMHSA/CSAT/DSCA
5600 Fishers Lane/Rockwall II, 8-147
Rockville, MD 20857
(301) 443-7615
E-Mail: rlopez@samhsa.gov

OR

Lawrence Rickards, Ph.D.
SAMHSA/CMHS/DSSI
5600 Fishers Lane, 11-C-05
Rockville, MD 20857
(301) 443-3707
E-Mail: lrickard@samhsa.gov

For questions on grants management issues, contact:

Stephan Hudak
SAMHSA/OPS/DGM
5600 Fishers Lane/ Rockwall II, 6th floor
Rockville, MD 20857
(301) 443-9666
E-Mail: shudak@samhsa.gov

Award Criteria

Only one award will be made per State.

Decisions to fund a grant are based on:

1. The strengths and weaknesses of the application as identified by the Peer Review Committee, and approved by the CSAT and CMHS National Advisory Councils.

2. Availability of funds.

3. Considerations to help achieve the COSIG goal of being a national program based on population, geographic, and service characteristics. To achieve this goal, SAMHSA may distribute awards to achieve balance among areas of the country, or with differing population, or urban/rural characteristics.

4. It is SAMHSA's intent to make awards to States at different levels of readiness or infrastructure development.

Post Award Requirements

1. Grantees must submit **quarterly progress and annual financial reports** and a **final report**. Each report must include evaluation results and required co-occurring performance measures. CSAT and CMHS Project Officers will use this information to determine progress of the grantee toward meeting its goals. Upon award, SAMHSA will provide each grantee technical assistance for completing and submitting the required quarterly reports.

The final report must summarize information from the quarterly reports and describe the accomplishments of the project and planned next steps for continuing to implement service delivery improvements after the grant period.

2. Grantees must attend (and, thus must budget for) two technical assistance meetings during each year of the grant. Each meeting will be three days. At a minimum, three persons (Project Director, Project Evaluator, and staff from the

Governor's Office) are expected to attend each meeting. These meetings will usually be held in the Washington, DC, area.

3. SAMHSA will provide post award support to grantees through technical assistance on clinical, programmatic, and evaluation issues. Applicants must agree to participate in these activities.

4. Applicants must commit to cooperating with, coordinating with, and supporting the efforts of SAMHSA's Co-occurring Cross Training and Technical Assistance Center (separately funded). The purpose of the Center is to provide broadly focused technical assistance and training to States and community agencies to enable them to provide effective prevention and treatment services to meet the needs of persons with, or at-risk of developing, co-occurring disorders (including the homeless), whether in the mental health, substance abuse, criminal justice, or other social/public health systems.

5. Grantees must inform the SAMHSA Project Officers of any publications based on the grant project, including publications occurring after the grant period ends.

Program Overview

A. Background

There is a growing consensus among key stakeholders about the critical importance of improving services to people with co-occurring disorders and the action steps that are needed to do so. SAMHSA released a landmark Report to Congress on Co-occurring Disorders (RTC) on December 2, 2002, creating a critical opportunity for SAMHSA to provide leadership to support State efforts to improve services for people with co-occurring disorders.

COSIG provides funding to the States to develop or enhance their infrastructure to increase their capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with co-occurring substance abuse and mental disorders. COSIG also provides an opportunity to evaluate the feasibility, validity and reliability of the proposed co-occurring performance measures for the future Performance Partnership Grants (PPGs).

COSIG is built on the following concepts and principles:

- COSIG uses the definition of co-occurring disorders developed by the consensus panel convened to draft SAMHSA's Treatment Improvement Protocol (TIP), *Substance Abuse Treatment for Persons with Co-occurring Disorders:* People with co-occurring substance abuse and mental disorders are "…individuals who have at least one psychiatric disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person (e.g., an episode of depression may trigger a relapse into alcohol abuse, or cocaine use may exacerbate schizophrenic symptoms) at least one disorder of each type can be diagnosed independently of the other."

- COSIG will support infrastructure development and services across the continuum of co-occurring disorders from least severe to most severe (i.e., Quadrants I, II, III, and IV of the State Directors' Conceptual Framework – See Appendix C). Under COSIG, SAMHSA's emphasis is on Quadrants II & III.

- COSIG is appropriate for States at any level of infrastructure development. States will not be at a disadvantage either for being at an early stage of development or at a more advanced stage.

- Some States and communities throughout the country already have initiated system-level changes and developed innovative programs that overcome barriers to providing services for individuals of all ages who have co-occurring substance abuse and mental disorders. The COSIG Grant program reflects the experience of States to date. [See Appendix A for references to case studies of these efforts.]

B. Program Requirements

In developing their COSIG applications, States will select one or more of the capacity building coals enunciated in SAMHSA's Report to Congress on Co-Occurring Disorders and will implement infrastructure development and enhancement activities (tailored to State needs) that will support the selected goal(s). Applicants will identify measurable outcomes for each goal, establish targets, and describe how progress will be tracked and measured over the course of the grant. In addition, all COSIG grantees will be required to report on the proposed co-occurring performance measures for the PPGs and to participate in an evaluation study to determine the feasibility, validity, and reliability of the co-occurring performance measures. This evaluation will be funded through a separate contract, though data collection and reporting costs are to be borne by the COSIG grantees.

COSIG program will have two phases:

- Phase I – The first three years of the grant will focus on infrastructure development/enhancement (as described below). Awards will be for up to $1.1 million per year for the first three years.

- Phase II – An additional 2 years of funding will be provided at a lower level for evaluation and continued collection/reporting of performance data. Grantees without service pilots (see below) will receive up to $100,000 per year in years 4 and 5. Grantees with service pilots will receive up to half of their third year award in year 4 and up to $100,000 in year 5.

The capacity building goals in SAMHSA's Co-Occurring Report to Congress are as follows:

- **Screen** all individuals for the presence of co-occurring disorders;
- **Assess** the level of severity of co-occurring disorders;
- **Treat** both disorders in a comprehensive and coordinated manner that is seamless to the client and, where feasible, that involves the client's family. This may involve consultation/collaboration with other providers, if the provider does not have the ability to offer comprehensive treatment;
- **Train** providers to screen, assess, and develop preventive interventions and treatment plans for people who have co-occurring disorders; and
- **Evaluate** the impact of prevention and treatment services on individuals who have co-occurring disorders and their families.

States will have flexibility to identify specific infrastructure development and enhancement activities that support the goals selected and respond to the needs and priorities identified by the State. However, the experience of other States suggests that certain areas of infrastructure development (e.g., standardized screening and assessment, complementary licensure and credentialing requirements, service coordination and network building, financial planning, and information sharing) reflect critical pathways for establishing complementary service delivery capacity in substance abuse and mental health service systems. Although COSIG awardees are not required to use COSIG funds in each of these areas, applicants must discuss in their applications the status of the State with regard to each area of infrastructure development, identify the area(s) that will be

targeted with COSIG funds and describe how the State proposes to use COSIG funds in each area selected.

- **Standardized Screening and Assessment**: A number of screening and assessment instruments exist that can be used to identify and effectively assess the needs of persons with co-occurring disorders. At present, there is no standard for using these instruments or for ensuring that screening and assessment are even done in existing programs throughout the States. Adoption of acceptable protocols State-wide can help ensure that the initial objectives of the SAMHSA Report to Congress are achieved.

- **Complementary Licensure and Credentialing Requirements:** State licensure and credentialing policies and legal requirements often act as barriers to providing effective integrated services for persons with co-occurring disorders. Review and revision of these laws and policies are a critical initial step toward improving services and extending effective substance abuse treatment to existing mental health treatment programs and vice versa.

- **Service Coordination and Network Building:** Conventional boundaries between single-focus agencies impede the clinical progress of persons with co-occurring disorders. Network building will help States develop more effective linkages across systems of care. This activity area also includes the development of a permanent State-level coordinating body and assignment of specific "boundary spanning" responsibilities designed to ensure continuous coordination which yields the most efficient use of agency resources and the elimination of service redundancies.

- **Financial Planning:** Current reimbursement practices inhibit coordination/integration of services and effective treatment for persons with co-occurring disorders. Mental health and substance abuse services are funded through separate Federal, State, local, and private funding sources. The goal of comprehensive financial planning is the development of effective and innovative approaches for coordinating funds from these multiple programs to fund seamless services for individuals with co-occurring disorders—while maintaining accountability—and the removal of barriers that inhibit effective resource coordination.

- **Information Sharing:** Often there is little or no communication among various departments and levels of government that have separate administrative structures, constituencies, mandates, and target groups. The goal of information sharing, ideally through utilization of the State's integrated MIS, is to ensure communication between providers so that treatment is more suited to the person's personal needs and characteristics by linking services and information across different systems of care.

The program will **allow** (but not require) up to 50% of the grant to be used for services pilots to test the infrastructure enhancements that are being made through the grant. In other words, these service pilots will help States who choose to implement them to determine whether the enhancements are feasible and whether they are resulting in the intended outcomes. Patient services are required in a pilot.

C. Evaluation/Performance Measurement

COSIG grantees will participate in two types of evaluation activity:

1) All grantees will participate in an evaluation of the feasibility, validity, and

reliability of the proposed co-occurring performance measures for the PPGs, and

2) All grantees will conduct a local evaluation to monitor individual grantee progress towards achieving the goals and outcomes identified in the COSIG application.

In addition to these two evaluation requirements, SAMHSA may choose to implement a cross-site evaluation of the COSIG grant program. If conducted, the cross-site evaluation will be managed through a public/private collaboration. States will be required to collaborate in the evaluation by attending up to two meetings annually, participating in the development of a cross-site evaluation plan, and by submitting information consistent with the plan. Applicants must specifically agree to participate in a cross-site evaluation and must budget for attendance by two persons at two meetings annually. These two annual meetings are in addition to the two annual technical assistance meetings discussed above.

Evaluation of Co-Occurring Performance Measures

All awardees will use the co-occurring performance measures adopted by National Association of State Alcohol and Drug Abuse Directors (NASADAD), and the National Association of State Mental Health Program Directors (NASMHPD), in conjunction with SAMHSA, to monitor the growth of their service capacity for treating persons with co-occurring disorders. Costs for collecting and reporting data on these measures should be included in the proposed budget for the COSIG. The co-occurring performance measures are as follows:

- Percentage of clients (adults and children/adolescents) in mental health and substance abuse programs with symptoms of the corresponding co-occurring problem;

- Percent of treatment programs that:
  - screen for co-occurring disorders;
  - assess for co-occurring disorders;
  - provide treatment to clients through collaborative, consultative and integrated models of care.

- Percentage of clients who experience reduced impairment from their co-occurring disorders following treatment.

Applicants must describe their current capacity to collect data relating to each of these measures, must present baseline data if available, and must project targets for these measures for each year of the COSIG grant. Applicants must describe how they will collect and report data related to the PPG measures during the first 6-8 months of the grant, and demonstrate a capacity to do so.

During the first 6-8 months of the grant, all COSIG awardees, along with other States, will participate in a consensus-based process to develop interim standards for collecting and reporting data on these performance measures. These interim standards will be used by all COSIG awardees during approximately months 7-18 of the grant project. SAMHSA will award a separate contract to evaluate the interim measures for validity and reliability and to develop final standards for these performance measures, using a consensus-based process involving the COSIG awardees and other States. Once the final standards for the performance measures are developed, COSIG awardees will be required to collect and report outcomes using the final standards for the remainder of their grants.

Project Evaluation

All awardees also must conduct a project evaluation to determine the effectiveness of the project in meeting its specific goals and objectives. The project evaluation should be designed to provide regular feedback to the project to help the project improve services. The project evaluation must incorporate but

should not be limited to co-occurring performance measures described above.

Because the COSIG projects will differ significantly, no single evaluation plan or design will apply to all applicants. Experimental or rigorous quasi-experimental evaluation designs are NOT required. In general, the applicant's project evaluation plan should include three major components:

- Implementation fidelity, addressing issues ***such as***: How closely did implementation match the plan? What types of deviation from the plan occurred? What led to the deviations? What impact did the deviations have on planned intervention and evaluation?

- Process, addressing issues ***such as***: What activities, events, and services were supported with COSIG Grant dollars? Who participated in these activities or received these services?

- Outcome, addressing issues ***such as***: What impact did the activities have on the system? What was the effect of treatment on service participants? What program/contextual factors were associated with outcomes? What client factors were associated with outcomes? How durable were the effects? How enduring or sustainable were changes in the service system or in clients?

CMHS has developed a variety of evaluation tools and guidelines that may assist applicants in the design and implementation of the evaluation. These materials are available for free downloads from: http://www.tecathsri.org.

D. Restrictions on Use of Funds

COSIG funds may not be used to:

- Provide services to incarcerated populations (defined as those persons in jail, detention facilities or in custody where they are not free to move about in the community).

- Provide residential treatment services when the residential facility has not yet been acquired, sited, approved and met all requirements for human habitation and services provision. (Expansion or enhancement of existing residential services is permissible.)

- Pay for the construction of any building or structure. [Applicants may request up to $75,000 for renovations and alterations of existing facilities over the entire project period.]

- Pay for housing other than residential treatment.

- Provide inpatient treatment or hospital-based detoxification services.

- Carry out syringe exchange programs, such as the purchase and distribution of syringes and/or needles.

- Pay for pharmacologies for HIV antiretroviral therapy, STDs, TB and hepatitis B and C.

How To Obtain SAMHSA's Treatment Improvement Protocol (TIP), *Substance Abuse Treatment for Persons with Co-occurring Disorders* and the *Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit*

Pre-Application

The SAMHSA-funded Treatment Improvement Protocol (TIP), *Substance Abuse Treatment for Persons with Co-occurring Disorders* and the *Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit* are not yet available for distribution to the general public. We fully expect that the TIP will be available for use when the grant awards are made. The Resource Kit is currently undergoing pilot testing. In the interim, to assist the States in preparing applications in response to this RFA, a limited number of copies of the TIP and Resource Kit are available exclusively for use by potential applicants. ***Potential applicants must not reproduce these copies and must return them to SAMHSA with the grant application.*** SAMHSA will track which States have received copies of each TIP and Resource Kit. ***If the copies received by State applicants are not returned with the application, then the application WILL NOT BE REVIEWED.***

To receive draft copies of *Treatment Improvement Protocol (TIP), Substance Abuse Treatment for Persons with Co-occurring Disorders* and the *Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource* Kit for use in preparing the application, provide your name, position title, mailing address for receipt of packages, email address, and phone number to:

Richard E. Lopez, J.D., Ph.D.
SAMHSA/CSAT/DSCA
5600 Fishers Lane/Rockwall II, 8-147
Rockville, MD 20857
(301) 443-7615
E-Mail: rlopez@samhsa.gov

OR

Lawrence Rickards, Ph.D.
SAMHSA/CMHS/DSSI
5600 Fishers Lane, 11-C-05
Rockville, MD 20857
(301) 443-3707
E-Mail: lrickard@samhsa.gov

If States receiving copies of SAMHSA's *Treatment Improvement Protocol (TIP), Substance Abuse Treatment for Persons with Co-occurring Disorders* and *Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit* decide not to apply, then they must *return the copies* to Dr. Lopez or Dr. Rickards at their respective addresses shown immediately above, *no later than the application due date*.

What to Include in Your Application

In order for your application to be complete, it must include the following in the order listed. Check off areas as you complete them for your application.

❑ 1. FACE PAGE

Use Standard Form 424, which is part of the PHS 5161-1. See Appendix A in Part II of the RFA for instructions. In signing the face page of the application, you are agreeing that the information is accurate and complete.

❑ 2. ABSTRACT

Your total abstract should not be longer than 35 lines. In the first 5 lines or less of your abstract, write a summary of your project that can be used, if your project is funded, in publications, reporting to Congress, or press releases.

❑ 3. TABLE OF CONTENTS

Include page numbers for each of the major sections of your application and for each appendix.

❑ 4. BUDGET FORM

Standard Form (SF) 424A, which is part of the PHS 5161-1 is to be used for the budget. Fill out sections B, C, and E of the SF 424A.

Follow instructions in Appendix B of Part II of the RFA.

❑ **5. PROJECT NARRATIVE AND SUPPORTING DOCUMENTATION**

The Project Narrative describes your project. It consists of Sections A through C. These sections may not be longer than 30 pages. More detailed information about Sections A through C follows #10 of this checklist.

❑ **Section A –** Documentation of Need/Proposed Approach

❑ **Section B** – Organizational and Staffing Plans

❑ **Section C** – Evaluation/ Methodology

The Supporting Documentation section of your application provides additional information necessary for the review of your application. This Supporting Documentation should be provided immediately following your Project Narrative in Sections D through G. There are no page limits for these sections, except for Section F, the Biographical Sketches/Job Descriptions.

❑ **Section D -** Literature Citations. This section must contain complete citations, including titles, dates, and all authors, for any literature you cite in your application.

❑ **Section E -** Budget Justification, Existing Resources, Other Support. You must provide a narrative justification of the items included in your proposed budget as well as a description of existing resources and other support you expect to receive for the proposed project. **(See Part II of the RFA, Example A, Justification).**

❑ **Section F** - Biographical Sketches and Job Descriptions

- Include a biographical sketch for the project director and for other key positions. Each sketch should not be longer than **2 pages**. If the person has not been hired, include a letter of commitment from the individual with a current biographical sketch.

- Include job descriptions for key personnel. They should not be longer than **1 page**.

- **Sample sketches and job descriptions are listed on page 22, Item 6 in the Program Narrative section of the PHS 5161-1.**

❑ **Section G -** SAMHSA's Participant Protection. The elements you need to address in this section are outlined after the Project Narrative description in this document.

❑ **6. APPENDICES 1 THROUGH 3**

- Use only the appendices listed below.

- **Do not** use appendices to extend or replace any of the sections of the Project Narrative unless specifically required in this RFA (reviewers will not consider them if you do).

- **Do not** use more than ***30*** pages total for appendices 1 and 2. Appendix 3 has no page limit.

Appendix 1:
Letters of Commitment/Support from stakeholders and project participants/involved agencies.

Appendix 2:
Sample Consent Forms.

Appendix 3:
Data Collection Instruments/Interview Protocols. Note: Appendix 3 has no page limit.

❑ **7. ASSURANCES**

Non-Construction Programs. Use Standard form 424B found in PHS 5161-1.

❑ **8. CERTIFICATIONS**

Use the "Certifications" forms, which can be found in PHS 5161-1. See Part II of the RFA for instructions.

❑ **9. DISCLOSURE OF LOBBYING ACTIVITIES (See form in PHS 5161-1)**

Appropriated funds, other than for normal and recognized executive-legislative relationships, may not be used for lobbying the Congress or State legislatures. Federal law prohibits the use of appropriated funds for publicity or propaganda purposes or for the preparation, distribution, or use of the information designed to support or defeat legislation pending before the Congress or State legislatures. This includes "grass roots" lobbying, which consists of appeals to members of the public suggesting that they contact their elected representatives to indicate their support for or opposition to pending legislation or to urge those representatives to vote in a particular way. (Please read **Part II** of the RFA for additional details.)

❑ **10. CHECKLIST** (Found in the PHS 5161-1)

You must complete the Checklist. See Part II, Appendix C of the RFA for detailed instructions.

Project Narrative

Sections A through C

In developing your application, use the instructions below that have been tailored to this program. These are to be used in lieu of the "Program Narrative" instructions found in the PHS 5161-1 on page 21.

Sections A through C are the Project Narrative of your application. These sections describe what you intend to do with your project**.** Below you will find detailed information on how to respond to Sections A through C. Sections A through C may not be longer than 30 pages.

- **Your application will be reviewed and scored against the requirements described below for sections A through *C.* These sections also function as review criteria.**
- A peer review committee will assign a point value to your application based on how well you address **each** of these sections.
- The number of points after each main heading shows the maximum number of points a review committee may assign to that category.
- Bullet statements do not have points assigned to them; they are provided to invite attention to important areas within the criterion.
- Reviewers will also be looking for evidence of cultural competence **in each section** of the Project Narrative. Points will be assigned based on how well you address cultural competency aspects of the review criteria. SAMHSA's guidelines for cultural competence are included in Part II of the RFA, Appendix D.

Section A: Documentation of Need/Proposed Approach (55 points)

[Note: If the applicant does not propose a Services Pilot, 55 points are allocated to Section A.1. If the applicant does propose a Services Pilot, 40 points are allocated to Section A.1. and 15 points are allocated to Section A.2.]

Section A.1. Current System and Proposed Activities.

In this section, the applicant should describe the current system and the proposed activities for affecting positive system change. Address plans to implement requirements in Section B, Program Requirements, under Program Overview. Applicants are encouraged to use organizational charts and/or logic model depictions to illustrate the current elements, linkages, lines of communications, coordination mechanisms, responsibilities, and authorities, as well as areas where potential improvements or attention are needed.

- Demonstrate a thorough understanding of co-occurring substance abuse and mental disorders, and the state-of-the art in providing a system of services for persons with co-occurring disorders.

- Demonstrate a thorough understanding of the State's current system of services for persons with co-occurring disorders. Describe the State's current infrastructure and capacity for providing coordinated/integrated services to persons with co-occurring disorders within both the State Mental Health Authority (SMHA) and Substance Abuse Authority (SSA) and other relevant agencies/systems. Describe structural components, such as dedicated staff time, routine training activities, organizational roles and responsibilities, and relationships and priority areas for the provision of coordinated/integrated services to persons with co-occurring disorders across all four Quadrants. Describe any major limitations or challenges within both the SMHA and the SSA and other relevant agencies/systems including staffing limitations, limits to statutory authorities, organizational imperatives, or budget constraints.

- Present and justify the State's plan for using COSIG funds to improve infrastructure and capacity to serve persons with co-occurring disorders. State clearly which (one or more) of the five SAMHSA capacity building goals the State is selecting to implement. Describe how the State will implement these goals, through specific infrastructure development/enhancement activities. Applicants will identify measurable outcomes for each goal, establish targets, and describe how progress will be tracked and measured over the course of the grant. Be sure to address all the critical areas of infrastructure development identified in Section B, Program Requirements, under Program Overview. Specify how gaps in the system will be narrowed and other expected results, including any products to be developed through the project. State which Quadrants will be affected by proposed activities and demonstrate how the proposed plan is consistent with SAMHSA's emphasis on infrastructure improvements within Quadrants II and III.

- Describe the involvement of the SMHA and the SSA and of other relevant systems/agencies, such as criminal justice, labor, housing, and social service agencies in the proposed project. Demonstrate how involvement of these systems or agencies will contribute to enduring infrastructure improvements. Note: Applicants are required to include letters of commitment and cooperation from these agencies. [Letters of Commitment/Support from each of the involved agencies and stakeholders must be provided in **Appendix 1** of the application].

- Describe the process for linking State-level planning and infrastructure development to regional, county, and community-based mental health and substance abuse organizations and their representatives. Describe the process for obtaining input and involving a diverse array of participants, including

representation from cultural/ethnic communities, potential service recipients, mental health consumers and their families, the recovery communities, public and private service providers, businesses, faith communities, primary care professionals and other relevant community groups. Demonstrate that these processes will contribute to enduring infrastructure improvements.

- Demonstrate that the proposed project is feasible and practical. Demonstrate that the applicant's history of working toward systems coordination/integration will contribute to the success of the project. Demonstrate the scope and feasibility of successful collaboration among State entities involved in the proposed project – e.g., inclusion of treatment **and** prevention; inclusion of public health entities other than those dealing with mental health and/or substance abuse (e.g., primary care providers, communicable diseases, school health); inclusion of funding-related entities, especially Medicaid; inclusion of corrections and criminal justice; linkage with drug courts; collaborations with social/welfare/vocational services, etc.

Section A.2. Services Pilot

In this Section, the applicant should describe and justify the implementation of a Services Pilot Project, if applicable. Applicants that do not plan to conduct a services pilot must state this intent.

- Describe and justify the proposed services pilot. State the goals and objectives of the proposed pilot and document that the services pilot will support the overall goals of your grant project. Describe the geographic area to be served. What are the demographic and clinical characteristics of persons who will receive services? Who will provide the services, and what services? Demonstrate the need for implementing the services pilot in the proposed area(s) and with the proposed population(s). Provide an unduplicated estimate of the number of persons to be served through the pilot for each year of the grant.

- Provide relevant and recent literature supporting your services pilot plan. Demonstrate that the proposed service model is a science/evidence-based practice based on scientifically derived theory.

- Demonstrate that the services pilot will help test the feasibility of the infrastructure enhancement at various levels, with the goal of improving the effectiveness and efficiency of service delivery, and will contribute to statewide changes in the system.

- Describe how the project will address age, race/ethnic, cultural, language, sexual orientation, disability, literacy, and gender issues relative to the target population.

- Demonstrate the effective involvement of the target population in the planning and design of the proposed services pilot.

Section B: Organizational and Staffing Plans (30 points)

- Demonstrate the organizational capability to implement the proposed plan. Describe the organizational structure, lines of supervision, and management oversight for the proposed project. Specifically, describe the plans for partnership between the Governor's Office, the SMHA and the SSA, and proposed protocols for ongoing communications and joint planning activities. Identify a lead agency, if appropriate, for purposes of administering the grant, and describe the rationale for selecting this agency as the lead.

- Demonstrate the qualifications and roles of key personnel including evaluation staff and the Program Director.

- Provide an organizational chart showing the organizational placement of key personnel involved in the project. The applicant may also provide other visual diagrams showing key organizational components involved in the planning efforts and the structure for the involvement of organizational leadership.

- Demonstrate that the facilities and equipment that will be used to implement the proposed work plan are adequate. Indicate if the facilities will be compliant with the requirements of the American with Disabilities Act (ADA).

- Affirm a commitment to comply with reporting requirements, to attend two technical assistance meetings annually, to participate in technical assistance activities, and to cooperate and coordinate with SAMHSA's Co-occurring Cross Training and Technical Assistance Activity [see Post Award Requirements section], and to participate in the cross-site evaluation, if SAMHSA elects to conduct it [see Evaluation/Performance Measurement section].

Section C: **Evaluation/Methodology (15 points)**

- Describe the State's current capacity to collect data related to the PPG measures. Present baseline data, if available, and project targets for these measures for each year of the grant. Describe plans to collect and report data related to the PPG measures during the first 6-8 months of the grant, and demonstrate a capacity to do so. Describe steps to be taken to enable the State to comply fully with PPG reporting requirements, and demonstrate the feasibility of implementing these steps.

- Describe a local evaluation plan that will provide useful information to the State about project progress. Describe plans for using evaluation findings to monitor and improve project implementation and to help implement durable improvements in the service delivery system. Describe and justify the targets and measures the applicant will use to track progress toward accomplishing implementation of the goals, plans to assess implementation fidelity, process and outcome, and plans to ensure the cultural appropriateness of the evaluation.

- Demonstrate appropriate plans for including members of the target population and/or their advocates in the design and implementation of the evaluation and in the interpretation of findings.

NOTE: Although the budget for the proposed project is not a review criterion, the Review Group will be asked to comment on the appropriateness of the budget after the merits of the application have been considered.

SAMHSA's Participant Protection Requirements

Part II of the PA/RFA provides a description of SAMHSA's Participant Protection Requirements and the Protection of Human Subjects Regulations.

The evaluation requirements as described in the "Project Narrative" section of this RFA are subject to the SAMHSA Participant Protection (SPP) provisions. However, applicants who propose to implement more in depth evaluation activities may be subject to the Federal provisions at 45 CFR Part 46 (Protection of Human Subjects). In

accordance with these provisions, evaluation approaches designed to conduct the systematic collection of data on individual clients require review and approval by an Institutional Review Board (IRB). These requirements apply whether SAMSHA funds or funds from other sources are used to carry out the evaluation activities.

SAMHSA will place restrictions on the use of funds until all participant protection issues are resolved. Problems with participant protection identified during peer review of your application may result in the delay of funding. See Part II of the RFA for more information on participant protection.

You must address each element regarding participant protection in your supporting documentation. If any one or all of the elements is not relevant to your project, you must document the reasons that the element(s) does not apply.

This information will:

1. Reveal if the protection of participants is adequate or if more protection is needed.

2. Be considered when making funding decisions

Projects may expose people to risks in many different ways. In this section of your application, you will need to:

- Identify and report any possible risks for participants in your project.

- State how you plan to protect participants from those risks.

- Discuss how each type of risk will be dealt with, or why it does not apply to the project.

Each of the following elements must be discussed:

❶ Protect Clients and Staff from Potential Risks

- Identify and describe any foreseeable physical, medical, psychological, social, legal, or other risks or adverse affects.

- Discuss risks that are due either to participation in the project itself, or to the evaluation activities.

- Describe the procedures that will be followed to minimize or protect participants against potential risks, including risks to confidentiality.

- Give plans to provide help if there are adverse effects to participants.

- Where appropriate, describe alternative treatments and procedures that may be beneficial to the participants. If you do not decide to use these other beneficial treatments, provide the reasons for not using them.

❷ Fair Selection of Participants

- Describe the target population(s) for the proposed project. Include age, gender, racial/ethnic background and note if the population includes homeless youth, foster children, children of substance abusers, pregnant women, or other groups.

- Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners, or others who are likely to be vulnerable to HIV/AIDS.

- Explain the reasons for including or excluding participants.

- Explain how you will recruit and select participants. Identify who will select participants.

❸ Absence of Coercion

- Explain if participation in the project is voluntary or required. Identify possible

reasons why it is required. For example, court orders requiring people to participate in a program.

- If you plan to pay participants, state how participants will be awarded money or gifts.

- State how volunteer participants will be told that they may receive services even if they do not complete the study.

❹ Data Collection

- Identify from whom you will collect data; for example, participants themselves, family members, teachers, others. Describe the data collection procedure and specify the sources for obtaining data; for example, school records, interviews, psychological assessments, questionnaires, observation, or other sources. Where data are to be collected through observational techniques, questionnaires, interviews, or other direct means, describe the data collection setting.

- Identify what type of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation or if other use(s) will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

- Provide in **Appendix 3**, "Data Collection Instruments/Interview Protocols," copies of all available data collection instruments and interview protocols that you plan to use.

❺ Privacy and Confidentiality:

- Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.

- Describe:
  - How you will use data collection instruments.
  - Where data will be stored.
  - Who will or will not have access to information.
  - How the identity of participants will be kept private. For example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

NOTE: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records according to the provisions of **Title 42 of the Code of Federal Regulations, Part II.**

❻ Adequate Consent Procedures:

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Include how the data will be used and how you will keep the data private.

- State:
  - Whether or not their participation is voluntary,
  - Their right to leave the project at any time without problems,
  - Possible risks from participation in the project,
  - Plans to protect clients from these risks.

- Explain how you will get consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

NOTE: If the project poses potential physical, medical, psychological, legal, social or other risks, you **must** get written informed consent.

- Indicate if you will get informed consent from participants or from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective

participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include sample consent forms in your **Appendix 2**, titled "Sample Consent Forms." If needed, give English translations.

NOTE: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases your project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both participant protection in treatment intervention and for the collection and use of data.

- Additionally, if other consents (e.g., consents to release information to others or gather information from others) will be used in your project, provide a description of the consents. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

❼ Risk/Benefit Discussion:

Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project.

Special Considerations and Requirements

SAMHSA's policies, special considerations and requirements related to grants and cooperative agreements are found in **Part II** of the RFA. The policies and special considerations that apply to this program are:

- Population Inclusion Requirement
- Government Performance Monitoring
- Healthy People 2010
- Letter of Intent
- Intergovernmental Review (E.O. 12372)
- SAMHSA Participant Protection

Appendix A: State Case Studies

Arizona

The SAPT and CMHS Block Grants have been used creatively to promote the development of services for people with co-occurring disorders. The original impetus for the Arizona Integrated Treatment Initiative was a SAMHSA Community Action Grant for Service System Change, coupled with other resources, including State appropriations and tobacco settlement funds.

Recognizing that individuals with co-occurring disorders were commonly found in both substance abuse and mental health service settings, the Arizona Department of Health Services' Division of Behavioral Health Services launched a major initiative in 1999 to develop a best practice treatment model for individuals with co-occurring disorders. The result was a statewide refocusing of service practices in the behavioral health care system.

In particular, the State chose to pursue a consensus-based practice development model to identify the principles and practices of integrated treatment within Arizona, with the knowledge that implementation of this model would vary within the State based on local resources and the characteristics of the individuals being served. Among the outcomes of this effort were:

1.*New Contract Language*. Contracts for regional behavioral health authorities were revised to include language regarding co-occurring disorders consistent with that contained in the CMHS Block Grant statute.

2.*New Policies and Guidelines*. A work group of local and national experts developed Service Planning Guidelines for Co-Occurring Disorders and revised the State's eligibility policy for people with serious mental illnesses. The new policy expedites entry into services, regardless of concurrent substance use, and allows for an expanded time frame to gather necessary records. This means that individuals are not denied eligibility based on the inability to clinically differentiate multiple disorders or for lack of information.

Consensus-Based System Change. One of the most significant findings of the Arizona initiative was that consensus-based system change encourages and sustains community action. System planners determined that had the initiative been developed in isolation at the State level and simply mandated by administrative requirement, the level of community "buy-in" needed to make change happen simply would not have taken place.

Connecticut

In 1995 the State of Connecticut created the Department of Mental Health and Addiction Services (DMHAS) as the Single State Agency for both mental health and substance abuse services for adults. The Connecticut Department of Children and Families (DCF) is charged with the care of youth for behavioral health services.

SAPT Block Grant funds are distributed across all DMHAS-funded substance abuse treatment programs, including programs that provide addiction services for people with both substance abuse disorders and co-occurring mental disorders. DMHAS, in coordination with DCF, uses CMHS Block Grant funds to fund and administer services for youth with serious emotional disturbances and adults with serious mental illness. Over the past several years, both an Alcohol and Drug Policy Council and a Mental Health Policy Council, with broad stakeholder representations jointly address policy and service issues related to the planning and coordination of adult and children's behavioral health services including those persons with co-occurring disorders.

DMHAS has directly focused SAPT Block Grant funds to provide services to adults with co-occurring substance abuse disorders and mental disorders in three methadone maintenance programs. These programs have implemented screening and assessment protocols to help identify clients with co-occurring mental disorders. Clients identified as possibly having a mental health disorder receive a full psychiatric assessment.

Clients determined to have a mild or moderate mental illness are seen by an on-site psychiatrist for medication review. They are assigned to a dual diagnosis counselor, and receive ongoing case management. The counselors also provide intensive, individual, or group counseling to these clients. Individuals diagnosed with a serious mental illness are referred to appropriate mental health services; care is coordinated across the two programs.

DMHAS continues to explore ways to enhance access to appropriate care for people with co-occurring substance abuse disorders and mental disorders. Various policy making and planning bodies within the State are involved in ongoing discussions regarding care coordination and implementation of best practices. The State has used State general fund dollars and other non-Block Grant resources to promote a coordinated system of care for individuals with co-occurring disorders.

New Mexico

In 1997, the State of New Mexico combined the Division of Mental Health and the Division of Substance Abuse into the Behavioral Health Services Division. The Division administers the SAPT and CMHS Block Grants and non-Medicaid mental health and substance abuse treatment funds. This integration has fostered significant collaboration between disciplines in policy and program implementation.

SAPT and CMHS Block Grant funds, as well as State appropriations in mental health and substance abuse, are used to develop system capacity for people with co-occurring disorders. As part of a statewide managed care initiative, the Behavioral Health Service Division implemented a regional model of service delivery that includes the following features:

I. Five regional contractors that are responsible for the delivery of continuum of care in mental health and substance abuse treatment;

II. Comprehensive Behavioral Health Standards established by the Division to guide service delivery, network management, and performance/outcome requirements; and

III. A Behavioral Health Information System to monitor contract compliance and service delivery protocols through standardized reporting and site visits.

Because New Mexico's system is based on the assumption that co-occurring disorders are an expectation and not an exception, both substance abuse and mental health treatment programs must screen all individuals for the presence of both disorders on a routine basis. All programs employ a "no wrong door" approach that welcomes and supports the individual. In addition to screening, standard practices include assessment by appropriately licensed practitioners, integrated treatment planning, and direct services for both substance abuse and mental disorders provided at the same time.

Some programs for individuals with co-occurring disorders have the in-house capacity to deliver services for both disorders; others coordinate services as part of a network of community partners. In addition, the system includes the capacity to address treatment and service needs throughout the entire continuum, including residential and hospital-based levels of care. The goal is to create a system that meets the standards of accessibility, integration, continuity, and comprehensiveness (Minkoff, 1998). A more comprehensive report on New Mexico's integrated services can be obtained by contacting SAMHSA's Office of Program, Planning, and Budget at (301) 443-4111.

Pennsylvania

In 1997, the Office of Mental Health and Substance Abuse Services in the Department of Public Welfare and the Bureau of Drug and Alcohol Programs in the Department of Health jointly sponsored a statewide Mental Illness and Substance Abuse (MISA) Consortium to examine integrated approaches in working with people who have co-occurring substance abuse disorders and mental disorders. Stakeholders from the mental health and drug and alcohol systems participated. The group's 1999 report recommended service and systems integration in four areas: assessment, professional credentialing and training, service standards, and adolescent services. Pennsylvania's MISA Pilot Project is the embodiment of those recommendations.

The MISA Pilot Project is a product of a collaboration between the State Departments of Health and the State Department of Public Welfare. Designed to promote systems and services integration for individuals with co-occurring substance abuse disorders and mental disorders, the project is composed of five county systems and a network of 11 providers offering integrated services. The network continues to expand as additional providers meet the required integrated service criteria. The projects total funding is $3.3 million annually and comes from the combined resources of three funding sources: State Intergovernmental Transfer Funds, CMHS Block Grant Funds, and the SAPT Block Grant Funds. Traditional reporting mechanisms are used for tracking and accountability.

Based on the consortium's recommendations, the State issued a solicitation for pilot projects to interested county mental health administrators and substance abuse directors. Available funds were to be used as seed money for development of program models that combine resources and

expertise from both the community mental health and drug and alcohol systems. Four adult and one child/adolescent proposal were selected for funding.

Mental health and drug and alcohol funds have been allocated to the projects over a 2-year period, with an additional year for evaluation by the Center for Mental Health Policy and Services Research at the University of Pennsylvania. All pilot projects provide a varying number of services that meet criteria for enhanced/integrated services for co-occurring disorders.

The pilot projects are being evaluated to determine the impact of integrated treatment and systems of care on client outcomes; the impact on client satisfaction; the potential of specialized co-occurring disorders integrated treatment and support services; and best practice models of system integration, representing a variety of strategies that can be replicated for adult and adolescent services. Ultimately, the projects are expected to generate ideas for future policy and program development and identify potential funding sources for co-occurring disorders services.

Texas

The Texas Commission on Alcohol and Drug Abuse and the Texas Department of Mental Health and Mental Retardation created and funded a dual diagnosis coordinator position in 1995 to help ensure coordination between the two agencies. This position is funded with SAPT and CMHS Block Grant and general revenue funds. These monies also are funding 16 dual diagnosis projects throughout Texas.

The Commission on Alcohol and Drug Abuse purchases "dual diagnosis specialized services" to offer a coordinated approach to the delivery of integrated substance abuse and mental health services. The programs link patients to mainstream substance abuse and mental health services through research-based engagement strategies, and provide specialized dual diagnosis training and case consultation to service providers

The target population includes people with substance abuse or dependence and a serious mental illness, including schizophrenia, major depression, and bipolar disorder. The State requires that "dual diagnosis specialized services" respond competently to age, gender, sexuality, geography, and culture for all people needing services in Texas. The Commission also provides statewide conferences on co-occurring disorders throughout the year to train staff and expand capacity to serve this population.

The Texas alcohol and drug and mental health agencies also have implemented significant system changes. To strengthen the ability of substance abuse providers to meet the multiple needs of people with co-occurring disorders and their families, the Commission on Alcohol and Drug Abuse has adopted statewide rules and regulations which require that mental health expertise be incorporated into existing programs and/or coordinated with other providers. These rules address requirements, including those for screening and admission, assessment, and treatment services for facilities licensed by the Commission. The two agencies operate under a Memorandum of Understanding (MOU) that addresses principles and practices for treating individuals with co-occurring disorders.

Wisconsin

In May 1996, then-Governor Tommy Thompson of Wisconsin, created the Blue Ribbon Commission on Mental Health to examine the mental health delivery system and propose changes that fostered system effectiveness in an environment emphasizing managed care, client outcomes, and performance contracting. The Bureau of Substance Abuse Services and the Bureau of Community Mental Health are currently working cooperatively to develop a coordinated and flexible managed care model of service delivery, that includes the design, implementation and evaluation of a single entry point for consumers of mental health, alcohol, and drug services. The initiative emphasizes recovery principles and a consumer-focused approach with long-term care enrollees. The target group for this model includes individuals with severe and persistent mental illness, including individuals in that group who have co-occurring disorders.

During fiscal year 2000, Wisconsin developed a coalition to address co-occurring substance abuse disorders and mental disorders among the aging population. Five regional training sessions with over 450 participants in attendance educated about, and enhanced coordination of, mental health and substance abuse interventions, including the provision of integrated treatment, for older adults. Both the coalition and training efforts have been in operation for approximately 2 years. Funding is aggregated from multiple sources, including the CMHS Block Grant.

In addition, the Bureau of Substance Abuse Services used SAPT Block Grant funding to develop eight women-specific treatment programs that either provide or refer their clients to qualified mental health services. Coordination of mental health services for substance abuse clients is required for State program certification.

Appendix B: National Treatment Plan

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) initiated *Changing the Conversation: Improving Substance Abuse Treatment: The National Treatment Plan Initiative* (NTP) to build on recent advances in the field, to bring together the best ideas about improving treatment, and to identify action recommendations that could translate ideas into practice.

The NTP combines the recommendations of five Expert Panels, with input from six public hearings and solicitation of experience and ideas through written and online comments, into a five-point strategy: (1) Invest for Results; (2) No Wrong Door to Treatment; (3) Commit to Quality; (4) Change Attitudes; and (5) Build Partnerships. The recommendations represent the collective vision of the participants in the NTP "conversation." The goal of these recommendations is to ensure that an individual needing treatment—regardless of the door or system through which he or she enters—will be identified and assessed and will receive treatment either directly or through appropriate referral. Systems must make every door the right door.

The NTP is a document for the entire substance abuse treatment field, not just CSAT. Implementing the NTP's recommendations go beyond CSAT or the Federal Government and will require commitments of energy and resources by a broad range of partners including State and local governments, providers, persons in recovery, foundations, researchers, the academic community, etc.

Copies of the NTP may be downloaded from the SAMHSA web site–www.samhsa.gov (click on CSAT and then on NTP) or ordered from the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686.

Appendix C: State Directors' Conceptual Framework

Just as individuals with co-occurring disorders are unique, so too are the service systems through which they receive their care. The conceptual framework that meeting participants proposed, which is outlined in this section, provides a common set of reference points and allows policy makers, providers, and funders to plan services for individuals regardless of their specific diagnoses or the current structure of the health care delivery system in their State or community.

The New York Model

James Stone, M.S.W., Commissioner of the New York State Office of Mental Health, presented a model his State uses to locate individuals with co-occurring mental health and substance abuse disorders on a continuum of care. The underlying assumption of the New York model is the fact that people with co- occurring disorders vary in the severity of their mental health and substance abuse disorders, from less severe mental health and substance abuse disorders to more severe mental health and substance abuse disorders. Individuals for whom one or the other disorder is predominant fall between these two groups.

Further, the model is based on the fact that these differences in severity determine the service system location in which individuals receive their care, including the primary health care, mental health care, and alcohol and other drug treatment systems, as well as the criminal justice system, the homeless service system, and so on.

Participants chose to elaborate on the framework by expanding on these specific areas of concern. Most importantly, it was agreed that the framework could accommodate service coordination needs and (at some future point) funding sources quite well. Each of three areas– severity, primary locus of care, and service coordination – is discussed below.

The Revised Framework

The conceptual framework that meeting participants developed expands on the New York model and represents a new paradigm for considering both the needs of individuals with co- occurring substance abuse and mental health disorders and the system characteristics required to address these needs. Unique features of this approach include the following:

•The revised framework is based on symptom multiplicity and severity, not on specific diagnoses, and uses language familiar to both mental health and substance abuse providers. As such, it encompasses the full range of people who have co- occurring substance abuse and mental health disorders. In addition, it points to windows of opportunity within which providers can act to prevent exacerbation of symptom severity.

•The framework permits discussion of co- occurring disorders along several dimensions, including symptom multiplicity and severity, locus of care, and degree of service coordination. It permits a number of key decisions to flow from it, including the level of service coordination required and the best use of available resources.

•The framework accommodates different levels of service coordination rather than specifying discrete service interventions. It represents a flexible approach that can be adopted or adapted for use in any service setting.

•The framework identifies two levels of service coordination–consultation and collaboration–that do not require fully integrated services. It points to the fact that individuals can be appropriately served with interventions that do not require full service integration. This is important for those service settings in which integration is not feasible or desirable, and for those individuals whose needs can be addressed with a minimum amount of system change.

Regardless of specific diagnoses, meeting participants agreed that individuals with co- occurring disorders fall into one of four major categories based on the severity of their mental health and substance abuse disorders:

•Category I. Less severe mental disorder/less severe substance disorder.
•Category II. More severe mental disorder/less severe substance disorder.
•Category III. Less severe mental disorder/more severe substance disorder.
•Category IV. More severe mental disorder/more severe substance disorder.

This is a simplified categorization that permits further discussion. Individuals at various stages of recovery from mental health and substance abuse disorders may move back and forth among these categories during the course of their disease.

States need to be most concerned with individuals in categories I and IV, meeting participants agreed. While individuals in categories II and III may be receiving some level of care in the substance abuse and mental health systems, respectively, category I – those individuals whose disorders are not severe enough to bring them to the attention of the mental health or substance abuse treatment systems at this time–is largely ignored. This group is of particular concern because it includes many children and adolescents at risk for developing more serious disease. Meeting participants agreed that providers may have the greatest impact in minimizing future disease by providing appropriate prevention and early intervention strategies for people in category I.

Members of category IV – those with more severe mental health and substance abuse disorders– are more likely to be found in inappropriate settings (e.g., jails, homeless), to use the most resources, and to have the worst outcomes. This group includes those with severe, chronic disease who may be the most difficult to serve. Because those in category IV consume the bulk of a system's resources, attention to people in this group may help reduce treatment costs and produce better consumer outcomes.

Using the revised framework, States can decide how best to direct their mental health and substance abuse efforts. For example, the framework encourages States to respond to the needs of those individuals who fall into category I by expanding their prevention and early intervention efforts. By the same token, States may choose to reduce expenses and improve outcomes associated with serving persons in category IV by diverting them from inappropriate and more costly treatment settings. In general, the framework supports State- directed efforts to work toward meaningful integration of services for these persons with the most severe mental health and substance abuse disorders.

Based on the severity of their disorders, people with co- occurring mental health and substance abuse disorders currently tend to receive their care in the following settings:

•Setting I. Primary health care settings, school- based clinics, community programs; no care.
•Setting II. Mental health system.
•Setting III. Substance abuse system.
•Setting IV. State hospitals, jails, prisons, forensic units, emergency rooms, homeless service programs, mental health and/or substance abuse system; no care.

As with categories of illness, the use of such clearly delineated settings is for ease of discussion. In reality, there is a great deal of overlap between and among these settings; individuals with different combinations of severity are served in all of the systems highlighted above. In addition, individuals may move back and forth throughout the system of care based on their level of recovery at any given time.

Service Coordination by Severity

Based on the severity of their disorders and the location of their care, the following levels of coordination among the substance abuse, mental health and primary health care systems is

recommended to address the needs of individuals with co-occurring mental health and substance abuse disorders:

•Level I. **Consultation**. Those informal relationships among providers that ensure both mental illness and substance abuse problems are addressed, especially with regard to identification, engagement, prevention, and early intervention. An example of such consultation might include a telephone request for information or advice regarding the etiology and clinical course of depression in a person abusing alcohol or drugs.

•Levels II/III. **Collaboration**. Those more formal relationships among providers that ensure both mental illness and substance abuse problems are included in the treatment regimen. An example of such collaboration might include interagency staffing conferences where representatives of both substance abuse and mental health agencies specifically contribute to the design of a treatment program for individuals with co- occurring disorders and contribute to service delivery.

•Level IV. **Integrated Services**. Those relationships among mental health and substance abuse providers in which the contributions of professionals in both fields are merged into a single treatment setting and treatment regimen.

Putting the Pieces Together

The revised framework has implications for funding strategies. For example, Dr. Pepper strongly recommended making better use of existing resources through coordinated or shared funding at the local service delivery level. This may be of particularly value for those individuals who fall in categories II and III. Reducing the use of inappropriate service settings (e.g. jails and prisons) for people in category IV would help save costs. Recognizing that a topic of such significance could not adequately be addressed within the scope of the current meeting, participants stressed that future attention be paid to the topic of funding opportunities.

Finally, the framework is a necessary, but not sufficient, piece of the puzzle. To accomplish system change for people with co-occurring mental health and substance abuse disorders, policy makers, funders, and providers must define an effective system of care and delineate what successful consultation, collaboration, and integration look like. These concepts are discussed in the next section.

The complete report is available for free download from: http://www.nasadad.org/